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Research Brief

In this study of comprehensive services for the blind, carried out at the Rehabilitation Institute in Detroit, the problem approached was the feasibility of operating rehabilitation training services within a "freestanding" general rehabilitation facility. It was hypothesized that if this could be accomplished, the services for blind and partially sighted adults would be more complete, efficient, and comprehensive than would normally be found in a separate facility designed to serve the special group only. These advantages would be inherent in the broad resources and variety of disciplines characterizing the general rehabilitation facility.

To accomplish this goal a specialized staff was recruited to provide rehabilitation counseling, training in independent mobility and communications techniques, and program coordination. Less specific needs, but equally important in the crucial prevocational adjustment period, were met through coordinated scheduling in the Institute's full-time departments, including physical and occupational therapy, social service, psychology, psychiatry, audiology, physiatrics, prevocational testing and training, and other consultant medical disciplines where prescribed.

The program was conducted over a five-year period, serving a total of 243 persons, of whom 115 received the full complement of training services for approximately three months in each case. Taking vocational placement as a criterion of success, 42 percent (49 persons) of the 115 were placed in jobs, as compared with 36.2 percent (88 persons) for the whole group. The percentage difference between the comprehensive and restricted groups was not significant but might be regarded as suggestive. Nor does this result differ materially from reports for groups in established separate facilities. The significant implication, however, is that these services, with the adaptations designed for this Project, can be rendered to these clients and can contribute to their independent and vocational growth without constructing a totally separate and often professionally isolated facility for the blind as such.

Supplementary to the above demonstration was a follow-up study by questionnaire and telephone; 104 clients responded giving detailed evaluation of program content. There are many implications for all adjustment program services and vocational training programs involving blind persons. Most of the questions raised warrant further study, particularly with respect to independent mobility. Communications training and the combined categories of occupational therapy and activities of daily living were second and third in frequency of mention by the respondents. Many clients indicated a need for more emphasis or added training toward particular vocations. The use of occlusion was controversial among the clients with residual sight. This opens up the entire area of training methods used with blind persons.

Because of the metropolitan setting of the Institute, none of the Division of Services for the Blind referred adult blind clients lived here as inpatients. Whether they remained in their own homes or had temporary accomodations nearer the Institute depended on their degree of mobility and the geographic factors. Practically all of the clients responding to the questionnaire felt that their particular outpatient arrangements had been best for them. On the questionnaire, 87 clients reported that they now travel alone, and 63 listed the bus as their mode of travel. This is felt to have been a very significant result of this Project.

The relevance of this project for rehabilitation counselors, social workers, and program administrators would seem to be to seek adjustment service for blind adults at the community level, with existing or expanded facilities. To accomplish this, proper regard must be given to the development of the specialized staff and the bodies of knowledge that pertain to the blind but not to disability groups in general. On the other hand, caution should be exerted so as not to exaggerate this specialty. With this achieved, clients can be referred to and trained in such facilities, and successful placement or further training will follow, eventually returning these persons to economic independence and productivity much sooner than can be the case with limited specialized facilities for the blind only.

The nature of the general rehabilitation facilities makes it more likely that the clients can be trained along with their family group in the home community. Vocational planning should reach a point where the training procedure will be accelerated, since contacts will be at the community level for an ever-broadening matrix of client services. This will be true within the rehabilitation center as well as in the client's community resources while he is living at home and later taking advantage of local training or educational facilities.

SIGNIFICANT FINDINGS

Of 243 persons served, 88 were placed vocationally, of whom 25 were homemakers. Eighty-two acquired subsequent training, primarily vocational. Forty-nine continued in academic education.

Of 115 fulfilling the complete comprehensive training program, 49 achieved vocational placement. The follow-up was done at the completion of a five-year study and research demonstration project.

Analysis of the results show that such a program has been successfully carried out in a general rehabilitation center.

In response to a questionnaire, 104 of the 243 persons reported their impressions of the program. Many of the respondents listed multiple preferences. Seventy-one recorded mobility, 43 communications, and 26 training in occupational therapy, as having been of most importance to them. Many of their general comments expressed a need for follow-up services of a more vocational nature. A need was also expressed by those with multiple disabilities for more specialized service concerned with the deaf-blind, brain-damaged, or a variety of other health problems.

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COMPREHENSIVE ADJUSTMENT SERVICES FOR THE BLIND

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October 1969

This investigation was supported, in part, by Research and Demonstration Grant Number RD-1480-S, from the Division of Research and Demonstration Grants, Social and Rehabilitation Services, Department of Health, Education, and Welfare, Washington, D.C., 20201.

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FOREWORD

This project was carried out to demonstrate the application of a concept that seemed unique in 1964. Looking at the broad areas of social progress in all areas of health service, the underlying concept now represents a trend that is expanding. It is anticipated that as blind adults are served qualitatively better, by the same disciplines and services that meet the needs of other disability groups, so will they fit more completely into society as a whole. It is hoped that jobs in competitive employment will be a result. This goal is furthered in its attainment by the fact that blind persons may remain in their normal community environment while being trained. Symbolically, more blind children are being educated in public schools than ever before (in excess of 50%). The program described in this report, is only part of a total picture of persons with disabilities being served better, or at least as well, by the health service professions as by separate specialists and facilities.

Joseph N. Schaeffer, M.D.
Director, Rehabilitation Institute

PREFACE

The aims of this project were: (1) to establish a service facility for blind individuals which would provide comprehensive, coordinated adjustment services toward maximum vocational and social rehabilitation; and (2) to demonstrate the feasibility and desirability of providing these services in an existing "general" rehabilitation hospital with out-patient facilities, rather than in a physically separate plant, separately staffed, as is the prevailing national practice.

ACKNOWLEDGMENTS

Acknowledgments are in order to the Community Survey Team of the American Foundation of the Blind, who in 1962 pointed out the need for a comprehensive training program for blind adults in this metropolitan area. The two directors of the Division of Services for the Blind offered the cooperation of their agency, without which the program could not have developed. This was continued by both their directors, counselors, and supervisors, in the final process of data collection. Consultant service and staff personnel have always been available from our community agency, the Metropolitan Society for the Blind.

ABSTRACT

An adjustment training and evaluation program for blind adults was established within a general rehabilitation setting. This training included independent mobility, Braille, typing, abacus, occupational therapy, physical therapy, activities of daily living, social service, and vocational counseling, with evaluation in audiology and psychological testing.

The problem had been that in the past, separate facilities had been designed for such training programs. Problems of staffing to provide adequate discipline coverage and financing could be reduced if already existing settings could meet the needs of such a blind population. Uniquely, the Rehabilitation Institute set out to realize this accomplishment.

The specialized staff included instructors in communications and mobility, a rehabilitation counselor, secretary, and program coordinator. Significant additions were: full utilization of the professional staffs of the Institute departments of occupational therapy, physical therapy, prevocational training and evaluation, psychology, social service, psychiatry, and audiology.

Referrals came from the State Division of Services for the Blind. In the five-year period, 243 persons were served, with 88, or 36.2%, being placed vocationally. Of the total groups, 82 received supplementary vocational training and 49 continued some type of formal academic education. The comprehensive training period covered approximately three months. The training was non-residential, consequently heavy emphasis was placed by the clients, on their experience in independent mobility. In response to the follow-up questionnaire, 71 of 104 respondents indicated that the chief present mode of travel was by bus.

From the above, we are led to conclude that rehabilitation training for many blind adults can most feasibly be carried on--with specialized adaptations--in existing rehabilitation facilities.

Introduction

The purpose of this five-year Research and Demonstration Project was to determine whether optimum training of adult-blind persons could be accomplished within a general rehabilitation hospital. The nature of the problem and the proposed method of solving it were described in an article entitled "Program to Ingegrate Blind Persons into Standard Areas of Rehabilitation Treatment," published in New Outlook for the Blind, December 1964.

The principle of training for adjustment to blindness was established some years ago, particularly through the accomplishments of two Veterans Administration facilities during World War II. This work led to the postwar creation of numerous separate state and regional facilities for special training of blind persons. The Spring Mill Conference Report of 1951, together with the subsequent New Orleans Conference and the 1966 Consideration of the COMSTAC standards for rehabilitation centers, constitute a record of developments in this aspect of rehabilitation therapy.

Our study was designed to explore the hypothesis that such training and evaluation in adjustment for blind persons might successfully be carried out as an integral part of a general rehabilitation service, thus preparing these individuals for vocational training. Our research problem centered on the unmet needs of blind adults in this metropolitan area (Detroit and its tri-county setting) in relation to ultimate placement in competitive employment. During the course of the research program, added special needs were disclosed which might well comprise auxiliary goals in future adjustment regimens. There were added findings also with respect to method--for example, it appeared that the outpatient status of the research subjects was not only feasible but actually beneficial in terms of mobility problems and exposure to public transportation facilities.

Our study sample consisted of those persons who received all or part of the services provided in this comprehensive training and evaluation program. The sample was drawn from the population of eligible clients of the referring state agency (Division of Services for the Blind). The majority of referrals were for persons living in this tri-county area; however, since there has been no other such service in Michigan, referrals were accepted regardless of geographical area. This was important to our theory that establishing these services in the existing Rehabilitation Institute would be a better solution to the problem of adjustment training than separate facilities scattered throughout the state. Local housing was arranged for patients coming from outside this metropolitan area.

Full-time staff members for the Project were recruited from the various pertinent specialities in rehabilitation; others were added as necessary during the five years of the research program. A marked advantage of the setting was that specialists from other training areas of the Institute were available to all clients in

the program for the blind. Thus it was possible to broaden the services and develop a flexible regimen well coordinated with respect to the use of time and space and the rate of progress of the individual patients.

This final report of the Project takes into account the dual nature of the problem: research and demonstration. Thus the methods section describes both the adjustment-training program as it was carried out within the Institute and the follow-up procedures necessary to evaluate the demonstration aspects of the program. Similarly, the results are presented in two phases: vocational adjustment of the clients as the standard criterion of successful rehabilitation, and the effectiveness of the training program from the viewpoint of the clients themselves.

METHODOLOGY

I. Experimental Program:

Demonstration of the feasibility of providing adjustment services for the blind in a general rehabilitation setting required the structuring of a general program, as follows: Legally blind (vision of less than 20/200 in the better eye, after correction, or a severely restricted field) adult clients were accepted on an outpatient basis and were provided training and evaluation services at the Rehabilitation Institute in Detroit. In most instances the program covered a three-month period, although individual plans could be either reduced or extended. Initially the evaluations were scheduled on a three-day basis; in 1966 the evaluation schedule was changed to five days. Thus the evaluations were more complete for those research subjects (roughly half the total series) who entered the Project after the change in schedule.

In general, the training areas for these blind clients were integrated with therapy services and directed activities for the other Institute patients. The disciplines involved included physical therapy, occupational therapy, psychology, psychiatry, physiatrics, audiology, communications, and social service. Special training areas included mobility in traveling, Braille techniques, use of the abacus, typing, and prevocational testing and training. Other specific needs were met as they arose, and medical consultations were arranged as indicated in individual cases.

Criteria for Selection of Patients: Criteria for admission were: The client be an adult (16 or over) with an approved rehabilitation plan from his referral agency--usually the Division of Services for the Blind. A recent medical examination must have been received by the Institute in advance, with a ophthalmological report. A letter of referral from the counselor stating a vocational objective, other goals, and a case history was requested, in addition to any existing social, educational or psychological reports known to the referring agency. A "Case Presentation Outline" was used (form included in Appendix). Early in the period, screening meetings were held twice monthly to review applicants. Later, these were dropped and the Institute scheduled its own admissions because of increased demand for service.

Project Staff: The specialized staff working exclusively with blind clients included a full-time coordinator and secretary and full-time instructors in mobility and communications. A rehabilitation counselor also was available full-time. Other staff members were added at intervals during the course of the Project. Persons available from the full-time staff of other Institute departments included the clinical psychologist and psychometrist, prevocational examiner and instructor, social workers, occupational and physical therapists, physiatrists, and audiologists.

Physical Therapy: The blind subjects took part in 30-minute group-therapy periods under the direction of a physical therapist, with orders prescribed by one of our staff physiatrists. In this group work, the emphasis was on spatial orientation, particularly walking in a straight line, localizing sounds, and practicing techniques that would improve posture and gait. A rating scale was designed to collect data concerning

the proficiency of the clients in this program. It is planned to continue to administer this scale at the beginning and end of each client's participation in the program over the next few years. The data will then be examined for possible significant findings concerning any particular characteristics that our group of referrals may manifest. We have corresponded with the Michigan School for the Blind, the Perkins School for the Blind, the Illinois Institute for the Blind and Visually Handicapped, and the Hines Veterans Hospital, concerning their data on the application of physical therapy to these training programs. Information about grant #OEG-4-7-062464-03bg, stressing mobility training, has been requested.

Occupational Therapy: Occupational therapists of the Institute worked with the blind clients as part of their routine caseload, which included patients with various types of physical disability. Evaluations of achievements in this area were carried out by means of the Southern California Kinesthesia and Tactile Perception Test. Observations were also recorded with respect to activities of daily living such as personal hygiene and grooming, cooking, and housekeeping, as well as spatial orientation and, where appropriate, woodworking and the use of hand and power tools. In working with the partially sighted, the practice of occlusion was often used as a technique. This was to achieve three purposes:
1. To stress the development of other modes of perception than sight;
2. To achieve standardization in testing or evaluation; 3. To aid in preparing the person for total blindness in the case of a progressive sight loss.

Prevocational Training: The prevocational battery developed for the blind includes: 2 point 1/8 inch spread pin-prick and the Nolan-Morris Roughness Discrimination Test (for tactual discrimination), the Minnesota Rate of Manipulation Test (gross grasp and release and gross arm movements), the Pennsylvania Bi-Manual Worksample (both hands working together cooperatively in small two-part nut and bolt assembly and disassembly), identification, counting and packaging of coins, packaging of small one and two-unit articles, construction and repair of extension cords, faucet repair, disassembly and assembly of carburetors and fuel pumps. Clients with high partial vision, are tested, when appropriate, with the Bennett Hand-Tool Dexterity Test (knowledge of mechanics' tools).

Some blind norms are available. Clients with partial vision may or may not be occluded, depending upon visual level, prognosis, and work efficiency. Clients are scheduled for one hour per day in the prevocational area, the number of appointments depending upon the client's needs. Following the evaluation, training is provided as needed to increase hand speed, accuracy, and basic motor skills.

Psychological Evaluation: The psychological test battery developed includes, the Wechsler Adult Intelligence Scale, Verbal portion, the Haptic Intelligence Scale for Adult Blind (a performance test), the Wide Range Achievement Test, Spelling section, the Gray Oral Reading Test, Comprehension section, the Strong or the Minnesota Vocational Interest Inventories, the Rotter Incomplete Sentences, and the California Psychological Inventory (a personality inventory). A few partially sighted individuals are testable essentially as fully sighted subjects.

Psychological Evaluation (cont.): The only test used for which norms for the blind are available is the HISAB (Haptic Intelligence Scale for Adult Blind). The tests originally designed as self-administered are read to clients, usually by volunteers through arrangement with the Institute's supervisor of volunteers, and occasionally administered by tape recorder. The test battery is comparable in scope to that used with fully sighted Institute clients. The time required to administer the battery to the blind is usually considerably longer.

Communication Techniques: The use of Braille is, of course, of paramount importance for blind patients. Training here included reading, writing, and the use of special devices such as Braille watches and clocks. Typing and the use of the abacus provided basic skills; telephone dialing also received attention. Dictaphone transcription was added to the typing course to encourage independent study, promote improvement in spelling, and specifically train persons strongly considered to be candidates for employment in Dictaphone stenography or medical records. A specially designed series of Dictabelts was used in the practice of Braille writing. The Illinois series of Braille texts, and more recently Braille in Brief, were used to teach the reading and writing of Braille. An advanced course (Grade 3 Braille) was available on an optional basis. In abacus, the basic processes of addition, subtraction, multiplication, and division were taught. The Cranmer Braille or large-print abacus manual formed the instructional materials. More complicated problems had been prepared for advanced practice. Teaching was done in classes of four or five.

Mobility Training: The area of mobility instruction represented the most frequent occurrence of a one-to-one ratio between instructor and client. The work was guided, in general, by an outline prepared early in the program. Indoor and outdoor cane techniques were taught at the beginning of the client's training period; instructors capitalized on the client's motivation to travel from home to the Institute and return. Clients were expected to plan routes, ride city buses, and locate addresses. Independent travel was significant to those clients who had not previously experienced this level of mobility.

While the many subjective aspects of mobility training and experience were hardly amenable to quantitative evaluation, it seems reasonable to assume that the clients' daily exposure to real situations and problems outside the hospital helped significantly in reinforcing the training and motivation in other areas of the adjustment training program.

Vocational Counseling: Clients were seen for 1 or 2 hours per week, depending on their need, by the vocational counselor, who encouraged discussion of other problems related to blindness, in addition to orientation and planning in vocational matters. Near the end of the training period, the counselor scheduled employment explorations, in actual on-the-job settings.

Group Counseling: Hourly group counseling sessions, scheduled four times a week, were led by staff members, who discussed topics related to their own areas. To vary the format, guest speakers presented occupational information from their respective fields of employment. In addition, role-playing was an important part of these sessions.

Other Services: Psychiatric screening was offered to all clients referred for evaluation unless this had otherwise been available to them.

Each client was seen for audiology screening. The hearing test involved measures of both air and bone conduction.

All clients were seen for medical screening by our staff physiatrists, who also took active part throughout the program as the need arose.

Social service workers were involved in the training of many clients.

All cases were periodically reviewed at staff meetings attended by representatives of all disciplines participating in the research and demonstration project.

II. Five-Year Follow-Up:

Routine follow-up studies were carried out annually, immediately after the end of the fiscal year. Information gained from such reviews helped in the ongoing evaluation of the program and in maintaining contact with clients who had moved on to the next stage of their general rehabilitation program, away from the Institute. For the purposes of the Project, however, such follow-up was too early to provide the needed data regarding vocational training--the criterion for success of the adjustment services. Therefore, the second phase of the Project was the complete follow-up of all cases that had been involved during the five-year term of the training and evaluation program.

This review involved two procedures: 1. a direct follow-up on each client's vocational status through contact with his counselor in the Division of Services for the Blind, or a reference to the files of that agency; 2. a specially designed questionnaire which was mailed to the last known address of each client served. Respondents to the questionnaire, for the purposes of this study, remained anonymous; a numbering code matched to the mailing list prevented duplication of follow-up for those who had already responded. A second mailing went to those who did not respond to the first, and telephone contact was made with a few individuals known to be in this vicinity. In June 1969, meetings were held with the staff of the Division of Services for the Blind, and follow-up correspondence regarding the job placements was completed in August.

Through these procedures it was possible to evaluate the results of the program itself and also the clients' attitudes toward the concept and implementation of the program.

RESULTS

I. Vocational Adjustment:

The principal measure of the success of an adjustment-services program

for the blind is the employment status, or stage of further training, of the individuals served. Our five-year review showed that 243 blind persons had been included in the Project, and 88, or 36.2 percent, of this group had entered active employment. Independent homemakers totaled 25, leaving 63 in competitive employment. In addition, 15, or about 6 percent, are still undergoing vocational training. Of the clients who undertook some other form of further training or education, 49 had enrolled in college, high school, or business school. Nine of the 243 clients had died.

Table 1 shows the job breakdown for the 88 in the employed group. It should be noted that the criterion of "competitive employment," as a measure of the success of our state-federal rehabilitation programs, must be qualified somewhat in its application to the prevocational or adjustment services for the blind. Thus, in addition to the 45 clients now employed in strictly competitive job situations, it can be assumed that those still in vocational training or college are "employable," and that those in sheltered employment are making a significant contribution toward their economic self-sufficiency. Moreover, many jobs in competitive areas are closed to blind persons either because of the nature of the work or discriminatory policies on the part of the employers. The broader horizon of the rehabilitation picture acknowledges the achievement of optimum independence, social integration, and worthwhile occupation, as important indices to the success of rehabilitation programs for blind or otherwise disabled individuals.

In connection with the philosophy of integrating blind persons into a general rehabilitation setting, it is perhaps significant that 9 of our "sheltered employment" clients are in shops serving other disability groups. None are in situations designated or structured for service to the blind population only.

Table 1.--Job Status Categories

Description	Number of Clients	Remarks
Saleswork	10	Vending Stands--7
Industrial	9	Aluminum Processing--1
X-Ray Dark Room Development	5	
Sheltered Shop	11	Homebound--1 Woodworking--1
Hospital Aide	5	
Teaching	4	
Medical Records Secretary	3	
Masseur	2	
Computer Programmer	2	
Musician	2	
Piano Tuner	1	
Social Service Worker	1	
Personnel Supervisor	2	
Postal Supervisor	1	
Child Care	1	
Cook	1	
Silk Screener	1	Display
Janitorial	2	

Total: Competitive and Sheltered Employment--63,
Homemakers--25,
Total Working--88

To permit an objective interpretation of the results, consideration should be directed to the intensity of the adjustment services in relation to number of clients. Of the total series of 243 clients, 115 received full comprehensive services, and 128 received limited or evaluative services. There were other differences related to the patients themselves. There were a few who were not recommended for comprehensive services either because they could not benefit from them or because the services could not be adapted to their needs. Examples would be: persons very severely retarded, persons whose social adjustment was inadequate for group-living situations, and persons with other disabilities, such as deafness, in addition to blindness. At follow-up it was found that 49 of the 115 fully served clients and 39 of the 128 limited-service clients were employed. Table 2 shows the results of the program in relation to caseload service.

The most striking result is the number of persons (82) who were involved in further training subsequent to their evaluation or comprehensive adjustment training at the Institute. This is highly consistent with present trends toward higher degrees of training for semi-skilled and skilled areas of employment in our contemporary economy. Such considerations, amplified by the clients' voluntary responses to the questionnaire, highlight the urgent need for the development of services for such groups as the deaf-blind and for those who need a residential setting away from home for their training.

The three persons noted in Table 2 as having been referred from the special training school represented a group of experimental evaluations. These had been performed with three adolescent students who had been committed in childhood to the training school, where they had been receiving specialized service for mentally deficient blind children. These three represented a group often unserved by vocational rehabilitation in the past. The evaluation here was combined with their continuing residence at the training school, and was followed by an intensively supervised "extended evaluation" in a sheltered workshop. At present one of the three is continuing in this evaluation, with the expectation of possible eventual sheltered employment.

In summary, the results show that an adjustment training program for adult blind persons has succeeded in a general rehabilitation hospital, as evidenced by the number already placed in jobs and those pursuing further education and training in preparation for employment. It is concluded that a totally separate facility specializing in services to the blind is not essential to achieve the desired result of readiness for the next training step in the rehabilitation process. Moreover, a wider variety of professional disciplines are available to blind citizens through their inclusion in the broader rehabilitation process.

Table 2.--Caseload-Service Results

Number	243
Total number employed	88
Number receiving full services	115
Employed	49
Number receiving limited services	128
Employed	39
Fully served clients not employed	66
Unemployed clients in high school or college	49
Clients in other training programs following adjustment-service Project	82
Number still in above programs	15
Clients accepted for special college preparatory program	33
Clients from special training-school program	3

Supplementary Table 2.--Categories of Employment

Professional	10
Sales	10
Service	15
Industrial	10
Entertainment	2
Computer Programming	2
Clerical	3
Sheltered Shop	11
Homemakers	25

II. Five-Year Follow-Up:

The second aspect of program analysis relates to the clients' attitudes and benefits which can be used for the future innovation and modification of adjustment services for the blind. These results, which are summarized in Tables 3A, 3B, and 3C, were tabulated from responses to the follow-up questionnaire (form included in the Appendix). Of the 243 clients on the list, 104 or 42.8 percent responded to the questionnaire.

It will be noted that there are duplicate references in the responses. The items concerning "What was of most help to you in the program?" were often answered by naming a training area such as mobility or communications. Those responses are a tabulation of one or two-item statements from each person answering. In the body of the questionnaire, the training areas were enumerated and a positive or negative response to each was called for. Most clients checked more than one of these, so that the itemized responses total considerably more than the number of respondents.

Table 3A.--Client Reactions to Program Content

Most Helpful	
Mobility	71
Communications	43
Occupational Therapy	29
Activities of Daily Living	26
Prevocational Training & Testing	9
Urban Living & Group Interaction	9
Skill Teaching	3
Social Service & Vocational Counseling	6
Physical Therapy	2
Job Preparation	3
Independence	3
Everything	4
Psychological Testing	2
Group Discussions	2
Medical Services	1
Recreation	1
Staff Contacts	1
No Value	6

Table 3B.--Client Reactions to Program Content

Least Important

Area	No. of Clients
Occupational Therapy	23
Prevocational Training & Testing	7
Activities of Daily Living	6
Social Service & Vocational Counseling	3
Physical Therapy	2
Braille	1
Psychiatry	1
Mobility	5
Recreation	3
Abacus	9
Psychological Testing	1
Group Discussion	4
Everything	2

Table 3C.--Client Reactions to Program Content

Positive and Negative Responses to Each Discipline

Discipline	Positive	Negative
Mobility	71	17
Physical Therapy	33	19
Communications	68	16
Prevocational Training & Testing	52	19
Social Service & Vocational Counseling	59	21
Recreation	53	16
Occupational Therapy	43	6
Activities of Daily Living	44	0
Occlusion during training helpful	26	16

Vision Since Training

Better	Worse	Same
6	17	50

It is clear that clients perceived services in mobility, communications, and occupational therapy as most valuable. Mobility services singly were referred to most often as of greatest importance (71 times). Most other training areas were mentioned, but not in such large numbers. A few single references are suggestive of their importance to program-planning, and quantitative emphasis may not be the chief measure of their relevance. Not all clients were seen in physical therapy, due to reasons of health, or some difficulty of scheduling in the early days of the development of our program. The very relevant reference to "group or urban living," indicates a vital aspect of this program, though by most students it was not visualized as a single discipline. We would

conclude that the needs of the clients clearly justify heavy emphasis on broad training in independent mobility, communications, and occupational therapy.

The figures related to persons experiencing visual change and those using occlusion are limited to persons who had partial sight, and in the latter case, to those who were occluded in the training process. The item on the questionnaire asking how the client felt about occlusion "now" was misinterpreted by the respondents and is therefore invalidated. Two persons attributed their vocational placement to permanently or temporarily improved vision. Responses to these items, on the whole, are too small to affect judgments concerning the training. In counseling, there was much agitation expressed about occlusion having the effect of "training legally blind people to be blind." The lower number of those expressing objection to occlusion suggests the existence of the strong emotional factor known to relate to acceptance of permanent or impending blindness, and related fears. Apparently, many felt less strongly about this method following realistic experiences that occurred after the adjustment training program. There is still enough sensitivity in this area to argue strongly for a critical re-evaluation of the use of occlusion with partially sighted persons. Its validity is accepted in the event of a negative visual prognosis. It is appropriate in the area of objective and standardized test and measurement. It must always be interpreted and presented to the client in an ordered manner in connection with his training schedule. Too often, it may be a technique we use for lack of a proved or better-disciplined approach to the problems of the partially sighted individual. It may be needed to emphasize the development of other perceptual modes, as well as the client's safety, in mobility and in machine operation. It may be in conflict with other simultaneous training with the use of optical aids and partial vision. This is an area demanding much more research, of a more basic than demonstrative nature.

Related to the mobility emphasis, there are some confirming observations of further interest: 87 clients stated they now travel alone; 12 said that they did not; buses were listed 63 times as the primary mode; walking 55 times; and cabs 7 times. The items concerning "confidence," "added services," "special devices," and "remarks," do not naturally fit into the body of Table 3, and are briefly summarized below.

Forty-six persons indicated they lived away from home during training. This meant in a hotel, college dormitory, with relatives in Detroit, or in a Y.M.C.A. or Y.W.C.A., while in our program. Fifty-one indicated they were able to live at home during training. Eighty-one of this total group felt their own arrangements were best for them, seven felt that their arrangements were not best. Part of the basis for such plans was the distance of the client's home from the Institute, and his ability to travel. Pre-college students were required to live in the University of Detroit dormitories with the regular summer-term students. Apparently, these practical considerations led the overwhelming majority of clients to feel they had the arrangements best for them, in a setting that permitted the client to live either at home or away. This also includes about a half-dozen multiply-disabled Institute inpatient cases.

Attitudes concerning increased feelings of confidence split about equally among the respondents. Fifty-one felt their family's confidence in them had increased, with 40 feeling it had not. Thirty-five stated they needed more services, 34 said they did not. The types of services that were felt should be added to or changed must be regarded from the point of view of the quality of original suggestion and schedule modifications. They included: more scheduling in areas such as Braille, typing, and abacus; requests (5) for mobility services beyond the program; requests for specific job or vocational training; emphasis on use of optical aids; specific orientation to a college campus; the need of services to the deaf-blind; and several advocated that services for the totally blind and the partially sighted be separated. These opinions must be accepted as valuable for future community and program planning, but separate community evaluation would be needed to make any statistically significant deduction from them.

The request for suggestions for the improvement of the program must be interpreted similarly, by representative examples of comments made. The need for longer training and more space and staff was expressed by several. A few mentioned elimination of training in occupational therapy. Others suggested that abacus be made optional for the pre-college students. More social activities were requested, and specific help in dealing with mannerisms or "blindisms." Others advocated fewer sessions of group counseling, but more vocational counseling. A feeling that there should be more "individualized training or scheduling," was noted 12 times, which is more common than other recommendations. One stated a "kinder staff attitude" was needed, with others strongly urging the continuation of the College Preparatory Program in the summer. In that regard, a divided residence at the University of Detroit dormitories, and the more independent living arrangement at the "co-op-like" convent, was a majority consensus of that group. The actual arrangement had been 75% of the eight-week period at the University of Detroit, and 25% in the "co-op" setting.

White canes, Leader Dogs, cooking aids, tools, Braille watches, Talking Books, Braillewriters, tape recorders, taped books, and script-writing boards, were all listed more than once as desirable special devices, but few were listed as many as 10 times. It can be assumed that many of these are in use and that most persons did not think of these as special devices to mention in their responses. It also seems to be a pattern that many blind persons depend heavily on the use that they learn to make of commonplace appliances, rather than seeking or ordering special devices from a geographically distant source. Better local availability might be helpful.

The areas receiving mention under "remarks" represent no single majority of opinion. Again, they are listed here to point to areas of need, as felt by the population we serve. They should direct us to constructive efforts in areas of felt need, quicker follow-up between training and going to work, a desire to see a more direct relationship between training and employment is expressed in a number of sentiments. Relating only to nonresidential programs such as ours, there is a conviction that improvements should be made in the living conditions for those living away from home. Specifically, this probably was expressed

by those experiencing the accommodations at the downtown Y.M.C.A., or lesser quality hotels used in the downtown area because of travel convenience. Diabetics, with problems of diet control, also mentioned this in connection with eating meals away from the Institute. There were also about a half-dozen remarks saying "good," or "worthwhile program." Several comments were recorded of a positive nature relating to the value derived from an association with other blind persons as a group. This was a temporary situation with therapeutic values. Unique to the integrated setting, were observations regarding inpatients with disabilities viewed by the blind patients as far more severe than that of blindness. Our physicians have also made reference to such comments from some of these disabled inpatients concerning the feeling that their particular disability is not as severe a problem as being blind would represent. Such interaction seems highly therapeutic, probably in many unrecorded ways.

An excellent suggestion was that all blind students in the college dormitory setting should room with another student who was sighted. This had not been done in each case, due to random selection, but would seem to be a very desirable plan. Additional individual comments ranged from "help with personal correspondence," through having been "harassed by the social worker," needing more money, more recreation, to services designed especially for the partially sighted. All of these must be treated in the emotional context of the psychology of the individual's feeling, but from them constructive re-examination and improved techniques can be derived.

Research and Development Activities: Some research and development activities evolved from this project. One of these was a limited study relating some psychological test findings to mobility. The results are consistent with published findings of others as follows: There is a statistically significant positive relationship between Pattern Board performance (from the HISAB) and mobility; a lesser but still significant positive relationship is shown between total HISAB performance and mobility; no significant relationship is shown between WAIS Verbal I.Q. and mobility. A "spatial perception and memory" factor may be particularly important for mobility and may be measurable separately.

Experience with the blind in this project led a psychology staff member to prepare a research proposal entitled, "A Predictive Study of Employability Among the Visually Impaired with the California Psychological Inventory." This study, to begin in the near future, is funded by the Manpower Administration, United States Department of Labor, and administered through the University of Michigan.

Recent acquisition of the Halstead-Reitan Neuropsychological test battery has permitted use of non-visual portions of the battery with blind subjects to explore the usefulness of the results for generating practical rehabilitation recommendations.

With equipment and consultation services from the blind program, the California Psychological Inventory was taped for machine administration to some blind clients, who responded by sorting cards into boxes. While there is a slight overall time saving through machine administration with alert subjects, the major advantages are: scheduling flexibility,

standardized presentation of items, and increased privacy for the client. The taped library of tests will be expanded in the future.

This project also made possible a unique training opportunity for students in rehabilitation and related disciplines. For example, two graduate students in Clinical Psychology from Wayne State University have completed training assignments at the Rehabilitation Institute and two additional students are currently in training. Few students in a comprehensive rehabilitation center have exposure to the problems of the blind; it is hoped that the training offered here will lead to eventual enhanced contributions to services and research.

Psychological Evaluation and Vocational Implications: Although not representative at all points of the full group of clients served, the following characteristics describe the 135 clients seen for psychological evaluation at the Rehabilitation Institute.

While clients tested ranged in age from 16 to 64 years; the typical client was young. The median age was 27 years and about 25% were under 20 years of age. Odds were about three to two that the client was male and also that he lived within the Detroit city limits. The probability was somewhat greater that he was white as compared to non-white.

Slightly more than half the clients had congenital visual defects. Furthermore, slightly over half the clients had residual sight. Frequent ophthalmological notations were: retinitis pigmentosa, congenital glaucoma, retrolental fibroplasia, diabetic retinopathy, or trauma. Multiple-physical or physical-emotional disablements were not uncommon.

Half the group reported 10 or more years of schooling. Younger clients often planned further education. About 15% of the clients reported partial to completed post-high school education; such as training in college, business, or technical schools. About 25% reported eight years of schooling or less.

There was a slightly greater probability that the client was single than having ever been married. Of those who had married, most reported having had children. Approximately 30% of those who had married described themselves as later separated, divorced, or widowed.

Vocationally, about 25% described themselves as students without substantial work histories. About 10% described past employment in business, managerial, supervisory, or professional activities. About 15% listed themselves in each of the following categories: clerical or sales activities; skilled or semi-skilled industrial work; and laboring. A few clients had worked only in a sheltered workshop; three were institutionalized mentally retarded patients. There was a sprinkling of vending stand operators, piano tuners, musicians, and door-to-door salespersons.

Psychological test results showed that there were more verbally bright individuals seen than would be predicted from Wechsler's proposed distribution of I.Q.s on the basis of representative national sampling of non-handicapped adults. For example, whereas the theoretical expectation

is for 25% of individuals to score above I.Q. 109, 35.3% of the 133 clients tested with the Verbal portion of the WAIS, attained scores above this level. Not all scores were shifted upward. There were 11.3% below I.Q. 80, whereas Wechsler listed 8.9% as the expectation. Presumably, the major factor accounting for these relatively high I.Q.s was the testing of a substantial number of clients who had previously been recommended for college admission.

The distribution of 115 HISAB I.Q.s showed a closer correspondence to Wechsler's expectations for the WAIS, though there were slightly more high and low client scores at the expense of middle scores.

Wechsler Verbal I.Q.s were available for 50 clients, listed as employed at the conclusion of the project. The distribution of their scores closely resembled that of the entire group tested. The distribution of 38 Haptic I.Q.s available on the employed, were less consistent with their full distribution but did not show systematic differences. There was a relationship between Wechsler and Haptic I.Q.s on the one hand, and certain types of employment, on the other. Homemakers and sheltered workshop employees comprised a larger percentage of the lower I.Q. employed than the remainder of the employed group. For example, one of 18 employed clients, with WAIS Verbal I.Q.s above 109, was in the homemaker-sheltered workshop group; whereas seven of 11 with I.Q.s below 90 were in this group. Because of the small numbers involved and the probability of selective factors operating, it should not be concluded that most blind homemakers are relatively dull mentally, or that sheltered workshop employment invariably means mental dullness.

For the California Psychological Inventory, the means of three clusters of scores were tabulated for each client tested. These clusters have been termed by other investigators, "social poise," "social conformity," and "independence of thought and action."

As a group, the six boys and seven girls aged 18 years or younger, produced scores on these factors approximating those reported in the test manual for their non-handicapped peers.

The 25 adult men, and 14 women tested fared less well on this inventory, relative to scores reported for non-handicapped socially functioning adults. Only in the instance of the "social conformity" factor for women, was the median client score about the same as that reported in the manual. Otherwise, 64 to 88% of client scores were below those in the reference groups. Particularly striking were the low "independence" scores for most of the adult clients.

Personality factors associated specifically with blindness in adults, may or may not be reflected in these results. It is plausible to expect that personality inventory scores of the disabled frequently would be deviant, perhaps reflecting the effects of emotional stress or restricted opportunities. Possibly the fact that the younger blind achieved scores comparable to non-handicapped youth indicates better preparation to deal with the consequences of blindness (especially since several were bright and college-bound). Another possibility is that the younger blind had less exposure to the economic impact of their disability. The small

number of clients studied, especially in the younger group, limits the confidence of these conclusions.

The results of the California Psychological Inventory were available on 12 of the clients listed as employed at the conclusion of the study. To the extent that conclusions can be drawn from this small sample, they parallel those made for the intelligence tests. That is, the distribution of scores is not clearly different from the full array, but those clients employed as homemakers, or in sheltered workshops, tended to have lower scores. Of the nine scores for the three clients so employed, eight scores were below the medians for the employed California Psychological Inventory tested group. The exception was one high "independence" score from a middle-aged housewife with low partial vision, crippling arthritis, and a hearing loss! Again, the few scores available should be kept in mind.

The Minnesota Vocational Interest Inventory designed for non-handicapped men of sub-professional aspirations or capability, was administered to 23 male clients.

Broad occupational areas most often favored (standard scores above 60) included: sales-office, health service, office work, and "clean hands" acitivities. Least favored (standard scores below 40) were: carpentry, mechanical, and outdoor activities. Intermediate were: electronics and food services. On the occupational scales portion, those occupations most often favored (standard score above 40) were: warehouseman, stock clerk, milkwagon driver, and baker. Those occupations rarely yielding high interest scores were: pressman, industrial education teacher, and machinist.

The clients tested usually preferred clean, well thought of work of a clerical, sales, or personal service variety as opposed to blue-collar, mechanical, or construction trade occupations. Their choices were doubtlessly influenced, though not necessarily entirely determined, by recognition of their visual limitations. The extent to which fully sighted but otherwise handicapped persons might show the same pattern of preferences is unknown. Similar variations might occur in a non-handicapped sighted group influenced by occupational status strivings. Not to be overlooked are the possibilities that some blind clients may feel that any substantial manual skill is out of the question for them, or feel that manual work automatically means terminal sheltered workshop employment, or that this inventory is not structured for the blind to best bring out manual interests.

The Strong Vocational Interest Blank was designed for non-handicapped individuals, primarily brighter young individuals who intend to acquire substantial education or training beyond the high school level. This blank was administered to 16 male clients.

Those occupations most frequently favored with A or B+ scores, were: computer programmer, farmer, production manager, and engineer. Of somewhat lesser popularity were: dentist, Air Force officer, musician-performer, pharmacist, and business education teacher. Those occupations rarely receiving high scores were: psychiatrist, school superintendent, minister, banker, sales manager, life insurance salesman, and manufacturing company

president. Two occupations, optometrist and policeman, did not receive any high scores.

If the conclusions typical of a non-handicapped population can be applied, it appears that the clients tested were most frequently interested in technical, managerial, and business endeavors. The interests also were often culturally "masculine" and several suggested "individualism."

Sixteen women were given the Strong Vocational Interest Blank. Ten women scored high (A or B+ scores) on the stenographer-secretary, office worker, and housewife scales. Four or five scored high on the buyer, elementary teacher, and speech pathologist scales. None scored high in the medical sciences group (dentist, laboratory technician) or the physical sciences group (math-science teacher, engineer). Health related services (e.g., occupational or physical therapist, nurse) rarely received high scores. The same was true of social services (social science teacher, social worker, lawyer, psychologist). Slightly more interest was shown in music (teacher or performer) and in verbal-linguistic activities (artist, author, librarian, English teacher).

Since the Strong forms for men and women are not directly comparable, and a greater proportion of non-college-bound women than men were tested with the Strong, comparisons between the sexes on this inventory are rather speculative. Nevertheless, it appeared that the women tested were more restricted and often more focused in their occupational interests than the men. The women's interests favored clerical-business and domestic activities. More women than men showed no high scores.

Interest inventories (either the Minnesota or Strong) were available on 15 clients, who were listed as employed at the end of the project. All employed clients showed at least one high interest score. The mean number of high preferences among the employed was 6.3 and each of four employed clients showed 9 high preferences. The absence of any high interest inventory scores seemed to be a negative prognostic sign for employment in this small group. Studies by others have suggested that interest inventory results can provide a useful index of work motivation. A possible example is a client with low intelligence tests scores (WAIS Verbal I.Q. 77; Haptic I.Q. 85) who became employed as a hospital aide. This individual had 9 high interest inventory preferences.

Prevocational evaluation indicated that 16 of 175 clients had adequate hand skills for their intended activities. Most of the clients received training and showed increased speed and accuracy.

Recommendations for Implementations: With regard to psychological test procedures, certain disadvantages of administration and scoring could be minimized if tapes of suitable tests could be made available to qualified examiners. Scoring from the answer cards usually used with blind clients, is a cumbersome procedure. Possibly, computer centers could score pre-punched IBM card sorts, or some other efficient mechanical scoring method could be devised. If these developments could be effected, the advantages would be: encouragement of comprehensive psychological examinations, better standardized examination conditions, enhanced client privacy of response, saving of professional time, and encouragement of

research through availability of large pools of test data at scoring centers.

Some topics which warrant research and development efforts are: devising vocational interest inventory items and keys suitable for the blind; and compiling and developing as necessary a neuropsychological test battery and norms for the blind, which can help generate productive research and practical educational-vocational recommendations for clients who may be brain damaged. Scientific scrutiny of such skills as mobility and Braille, could result in improved teaching methods. On this last point, this project, as well as studies by others, raise some questions about the meaning of the relationship shown between mobility skills and other measures of what appear to be spatial orientation and memory. Considering this relationship, would improved mobility skills also yield improvement in certain hand skills?

Could a performance test be developed to diagnosis a mobility problem?

Regarding problems in the education of the blind, particularly with respect to blind youth, deficiencies in verbal-linguistic skills (e.g. active vocabulary, spelling, range of information) were observed frequently in the clients studied. Such deficiencies become critical for those who intend to enter college or occupations such as Dictaphone typing.

Deficiencies in basic motor skills were also frequently noted in the blind. It is ironic that some of the mentally retarded blind in the study had surprisingly adequate verbal facility and Braille skills. Presumably this reflected academic emphasis. They did not have the most elementary conception of the use of hand tools or of acceptable work habits, though their employment opportunities will probably involve manual skills.

Factors retarding verbal-linguistic and manual skill development appear to include the following: the effects of cultural deprivation or overprotection, resistance to reading or the use of reading substitutions, inadequate services or equipment, and negative occupational status connotations of hand skills.

Perhaps the following would be helpful measures: mounting an educational campaign for the parents and teachers of blind children about the importance of language and motor skill development; more use of educational radio, television, tapes, and Talking Books; encouragement of discussion groups of mixed blind and sighted students; promotion of hobby clubs, shop activities and recreational endeavors in which the blind can participate; systematic achievement testing with remedial work and counseling made available as needed.

CONCLUSION

To conclude, the results of this Research and Demonstration Project over a period of five years, established the feasibility of an adjustment training program for blind adults carried out in a general rehabilitation hospital. Almost 250 persons received service and 36% of them achieved

vocational placement. Also, 35% of the total number engaged in some form of subsequent rehabilitation training. Besides the vocational results, the findings suggest some factors requiring greater study concerning the operation of these programs. Questions raised are those regarding occlusion of partially sighted persons, more emphasis on training potentials as derived from experiences with physical therapy and activities of daily living, the broadening of psychological testing, and the effect of nonresidential living situations on earlier use of mobility training in the extensive use of public transportation. One recommendation that may immediately be pursued is that of providing a more specific service to family members of the blind person, in this local vicinity. This was suggested by the questionnaire findings; it had not before been fully explored. There appears to be a need for more attention and coordination directed toward placement and follow-through, between the several agencies involved at different times in the training of any one client.

BIBLIOGRAPHY

"Adjustment and Prevocational Training Program for Adult Blind and Partially Seeing." Final Report RD-1770.

American Foundation for the Blind, "A Survey of Services for the Blind." November 1960.

American Foundation for the Blind, "Adjustment Centers for the Blind." Spring Mill Conference Report, 1951.

Bauman, Mary K., Scholl, Gertrude T., and Skodak, Marie, "A Study of the Vocational Success of Groups of the Visually Handicapped." University of Michigan, RD-2554-S (currently in preparation for publication).

Bloom, Jean, Ph.D., Match, Elmer, Ed.D., and Rowe, Maryann, "Integration of the Visually Limited into a Comprehensive Rehabilitation Center." New Outlook for the Blind, v.63, No.7 (September 1969), pp.193-195.

Commission on Standards and Accreditation of Services for the Blind, The COMSTAC Report: Standards for Strengthened Services; ed. by Koestler. New York, 1966.

Dauterman, William, "Comments on Attitudes and Practices of Agencies for the Blind." Journal of Rehabilitation, v.34, No.6 (November-December 1968), p.31.

Gallagher, Patricia, "A Correlation Study of HAPTIC Subtest Scores and Travel Rating Skills of Blind Adolescents." New Outlook for the Blind, v.62, No.8 (October 1968), pp.240-246.

Kumpe, Roy, "Preparation of Blind Prospective College Students." The International Journal for the Education of the Blind, v.18, No.3 (October 1968), pp.79-81.

"Mobility and Orientation Instruction of Blind People." Final Report RD-1616.

"Preliminary Standardization of a Scale of Orientation and Mobility Skills of Young Blind Children." Grant OEG-4-7-062464-03bg.

Schaeffer, Joseph N., M.D., "Program to Integrate Blind Persons into Standard Areas of Rehabilitation Treatment." New Outlook for the Blind, v.58, No.10 (December 1964), p.315.

Thume, Lyle H., "Rehabilitation for Whom." New Outlook for the Blind, v.54, No.1 (January 1960), pp.22-25.

United States Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, "Rehabilitation Centers for Blind Persons." New Orleans Seminar Report, 1957.

Appendix I - Survey Questionnaire

1. How long did you spend in the program? ______________________________

____

2. What did you value most from the program? ____________________________

____

3. What did you find of least importance to you? __________________________

____

4. If you participated in any of the following areas, indicate whether or not you benefited from them:

Mobility--traveling with a long cane Yes___ No___

Physical Therapy--physical fitness and conditioning Yes___ No___

Communications--braille, typing, abacus, spelling Yes___ No___

Prevocational Testing and Training--learning to work with your hands

Yes___ No___

Social Service and Vocational Counseling Yes___ No___

Recreation Yes___ No___

Occupational Therapy (check areas from which you benefited)

___ Crafts & Woodworking

___ Personal Grooming

___ Handling Food & Eating

___ Household Activities

___ Handwriting

___ Others, list ____________

4b. Indicate which was most helpful to you ______________________________

____

5. How would you like to improve the program? ___________________________

____

6. If you used a blindfold during your training, did you find its use helpful?

At that time Yes___ No___ At present Yes___ No___

7. Since leaving the program, has your vision changed? Better___ Worse___ Same___

8. Do you travel by yourself? Yes___ No___

9. When traveling, are you mist likely to: Take a bus___ Use a cab___ Walk___

10. Did you live away from home while you were in training? Yes___ No___

11. Was this arrangement best for you? Yes___ No___

12. If you use special devices such as mobility or optical aids, kitchen aids or tools, list the ones most helpful to you in each category:

____

____

____

13. Are you aware of any difference in your family's confidence in you?
Yes___ No___

14. In what ways do you feel more confident? ________________

____

____

15. Are you in need of additional services? (Please specify) ________

____

____

REMARKS: ________________________________

____

____

Appendix II - Case Presentation Outline

Referral Agency ____________________________ Date __________

Identifying Information:

Name and Address ____

City __________ County __________ State __________ Telephone No. ________

Date of Birth __________ Cause of Blindness ____________________

Date of Onset of Blindness ________ Visual Acuity: Right _____ Left _______

Other Non-Visual Disabilities ______________________________

Social History:

Place of Birth ______________ Marital Status ______ Race ____________

Relatives:

Name	Age	Relationship	Occupation

Educational History:

Name of School, College, etc.	Grades Completed	Date Completed

Work History:

Name of Employer	Position	Dates of Employment

Financial Status:

Source of Support (List monthly amount)

Public Assistance _____ D.O.A.S.I. ________ Workmen's Compensation_____

Insurance _______ Other sources ____________________________

Objectives:

____

____

Additional Remarks:

____

____

____

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